DISCHARGE DATA DISCLOSURE REPORTING
EXTENSION REQUEST

To: Office of Statewide Health Planning and Development
Healthcare Information Division
818 K Street, Room 100
Sacramento, CA 95814
Fax No. (916) 327-1262

ATTN: Patient Discharge Data Section

Date: _____

1. Hospital Name (DBA):

   _____

2. Address:

   _____

3. Mailing Address (if different):

   _____

4. Hospital Identification Number:

   _____

5. Report Period Beginning Date:

   _____

6. Report Period Ending Date:

   _____

7. Designated Agent (if applicable): _____

8. Number of Days of Extension Request: _____

9. Justification: (Include actions taken to produce the data by the required deadline, and factors that prevent submission of the data by the deadline, and actions to be taken and the time needed to accommodate them):

   _____

   _____

   _____

   _____

   _____

   _____

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   _____

   _____

   _____

   _____

_____

_____

_____

10. Person Requesting Extension (print):

    _____

11. Signature:

    _____

12. Title:

    _____

13. Phone:

    _____

DD1805 (Rev 12/07/98)